

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Iron Deficiency Anemia ICD-10 Code: D50.9
 _____ Iron Deficiency Anemia secondary to blood loss (chronic) ICD-10 Code: D50.0
 _____ Anemia complicating pregnancy ICD-10 Code: O99.019
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
 - Recent lab results including a hemoglobin, hematocrit and iron studies
- Infusion Center — Lab Orders: _____

Patient
Weight: _____ lbs.
Height: _____ in.

FERAHEME® (ferumoxytol injection)

J Code: Q0138

4. Drug Order:

- ☐ Administer 510 mg Feraheme IV followed by a second 510 mg Feraheme dose 3-8 days after the initial dose
- ☐ Other: _____

*** Intramed Plus may contact you to discuss other iron formulations based on patient's insurance coverage***

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved protocol.

Pre-Medication Orders: _____
 No Pre-medications are recommended based on manufacturer guidelines.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ **Date:** _____
 Dispense as written Substitution permitted

Printed Physician's Name: _____ **Contact Phone #:** _____

FAX ALL INFORMATION
CENTRAL FAX 803.999.1754

CENTRAL INTAKE PHONE
803.999.1750